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Transitioning Individuals Within Medicaid Eligibility Groups and Between Medicaid and CHIP at Renewal

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Materials Overview

- Federal Renewal Requirements
- Transitions for:
  - Children from Medicaid to CHIP and from CHIP to Medicaid
  - Individuals Within Medicaid Eligibility Groups

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Federal Renewal Requirements

Federal Requirements for Conducting Renewals for Medicaid and CHIP

- States must renew eligibility once (and only once) every 12 months for beneficiaries whose eligibility is based on Modified Adjusted Gross Income (MAGI) and at least once every 12 months for non-MAGI beneficiaries.

- The state agency **must begin the renewal process** by first attempting to redetermine eligibility based on reliable information available to the agency (e.g. from the beneficiary's account and electronic data sources) without requiring information from the individual (*ex parte* renewal).
  - If available information is sufficient to determine continued eligibility without requiring information from the individual, the agency must renew eligibility on an ***ex parte* basis** and notify the beneficiary that coverage has been renewed.
  - If available information is insufficient to determine continued eligibility, the agency must provide the beneficiary with a renewal form and inform the individual of any additional information or documentation needed to determine eligibility.

Sources: 2 C.F.R. §§ 435.916; 457.343;
CMCS Informational Bulletin: Medicaid and CHIP Renewal requirements

The *Ex Parte* Renewal Process

As outlined in the "Medicaid and Children's Health Insurance Program (CHIP) Renewal Requirements" CMCS Informational Bulletin (CIB) and other guidance:

- State agencies must attempt to renew eligibility for *all individuals* enrolled in Medicaid, CHIP, or a BHP on an *ex parte* basis, based on reliable information contained in the beneficiary's account or other more current information available to the agency, without requiring information from the beneficiary.
- If an *ex parte* renewal cannot be completed because information needed to make a determination of eligibility is missing, or available information suggests that a beneficiary may be ineligible, states must send a renewal form and provide sufficient time for the family to return needed information to complete the renewal.

Sources:

42 C.F.R. §§ 435.916(a)(2) and (b); 457.343, and 600.340;

CMCS Informational Bulletin: Medicaid and CHIP Renewal requirements;

Ex Parte Renewals: Strategies to Maximize Automation, Increase Renewal Rates, and Support Unwinding Efforts

Considering Eligibility on Other Bases and Eligibility for Other Insurance Affordability Programs

Considerations for Medicaid Programs

- If the Medicaid program has sufficient information to determine that the Medicaid beneficiary is no longer eligible for the eligibility group in which the beneficiary is enrolled, it must consider whether the beneficiary may be eligible under one or more other eligibility groups covered by the state prior to terminating eligibility.
- If the Medicaid program identifies another eligibility group for which a beneficiary may be eligible, but requires additional information to make the determination, it must request additional information from the beneficiary and give the beneficiary a reasonable amount of time to provide the information.
- The Medicaid program may not terminate the beneficiary's coverage and must continue to furnish Medicaid benefits until:
  - A beneficiary is found ineligible under all groups covered by the state for which the beneficiary may be eligible or until the beneficiary does not provide requested information that is needed to make a determination in a timely manner, and
  - The beneficiary is provided advance notice of and fair hearing rights regarding the termination.
- If the Medicaid program determines that an individual is ineligible for Medicaid under any basis, it must determine potential eligibility for other insurance affordability programs (e.g., Separate CHIP or Marketplace coverage) and transfer that individual's electronic account to such program, as appropriate.

Considerations for Separate CHIPs

- If a state determines that a Separate CHIP beneficiary is no longer eligible, it must screen the individual for eligibility in other insurance affordability programs, including Medicaid and Marketplace coverage, on all bases.
- If the child is determined potentially eligible for another coverage program, the state must transfer the child's account to that program.

42 C.F.R. §§ 435.916(f); 435.930(b); 435.1200; 457.350(b); Part 431 subpart E.

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Transitions for Children from Medicaid to CHIP and from CHIP to Medicaid

Medicaid-Enrolled Children Who Appear CHIP-Eligible Via *Ex Parte* and Review and Return the Renewal Form

Question: If a state conducts an *ex parte* review at renewal and a Medicaid enrolled child appears eligible for a separate CHIP based on available data, what are the required state actions?

The state is required to:

- Maintain the child in Medicaid coverage;
- Send a renewal form to the family, requesting additional information needed to complete a determination for Medicaid; and
- Provide a minimum of 30 days to respond, if enrolled on MAGI basis, and a reasonable amount of time to respond if enrolled on a non-MAGI basis.

If the household* returns the renewal form ...

The state must determine eligibility based on the information provided.

If the information provided by the household indicates **continued eligibility for Medicaid:**

- The state must **renew the child's Medicaid eligibility**.

If the child is now **eligible for a separate CHIP** based on the information provided in the renewal form:

- The state must disenroll the child from Medicaid, with advance notice and fair hearing rights, and **enroll the child in CHIP**. In some states, the family may need to pay a premium prior to enrollment.

**Reminder that renewals must be conducted at the individual level but renewal forms for requests for information may be sent to the household.*

Next Slide: If the household does not return the renewal form

Medicaid-Enrolled Children Who Appear CHIP Eligible Via *Ex Parte* But Do Not Return the Renewal Form

If the household does not return the renewal form, the state has three options…

Option 1: Enroll Child in CHIP

- **Disenroll the child from Medicaid.** The state must send an advance notice of termination with fair hearing rights prior to the eligibility change.
- **Enroll the child in CHIP** based on available information from the *ex parte* process (including potential non-financial eligibility criteria.)
- States are **strongly encouraged** to elect this option to:
  - Maximize continuity of coverage for children; and
  - Minimize the family and state administrative burden of having to reenroll the child into CHIP at a later period.

Option 2: Request Additional Information At Least Twice

- State makes a minimum of two attempts to obtain information from the family.

Attempt 1:

- The renewal form must include a notice informing the household that a response is needed to determine eligibility for CHIP.
- If no response: The state disenrolls the child from Medicaid. The state must send an advance notice of termination with fair hearing rights prior to the eligibility change.

Attempt 2:

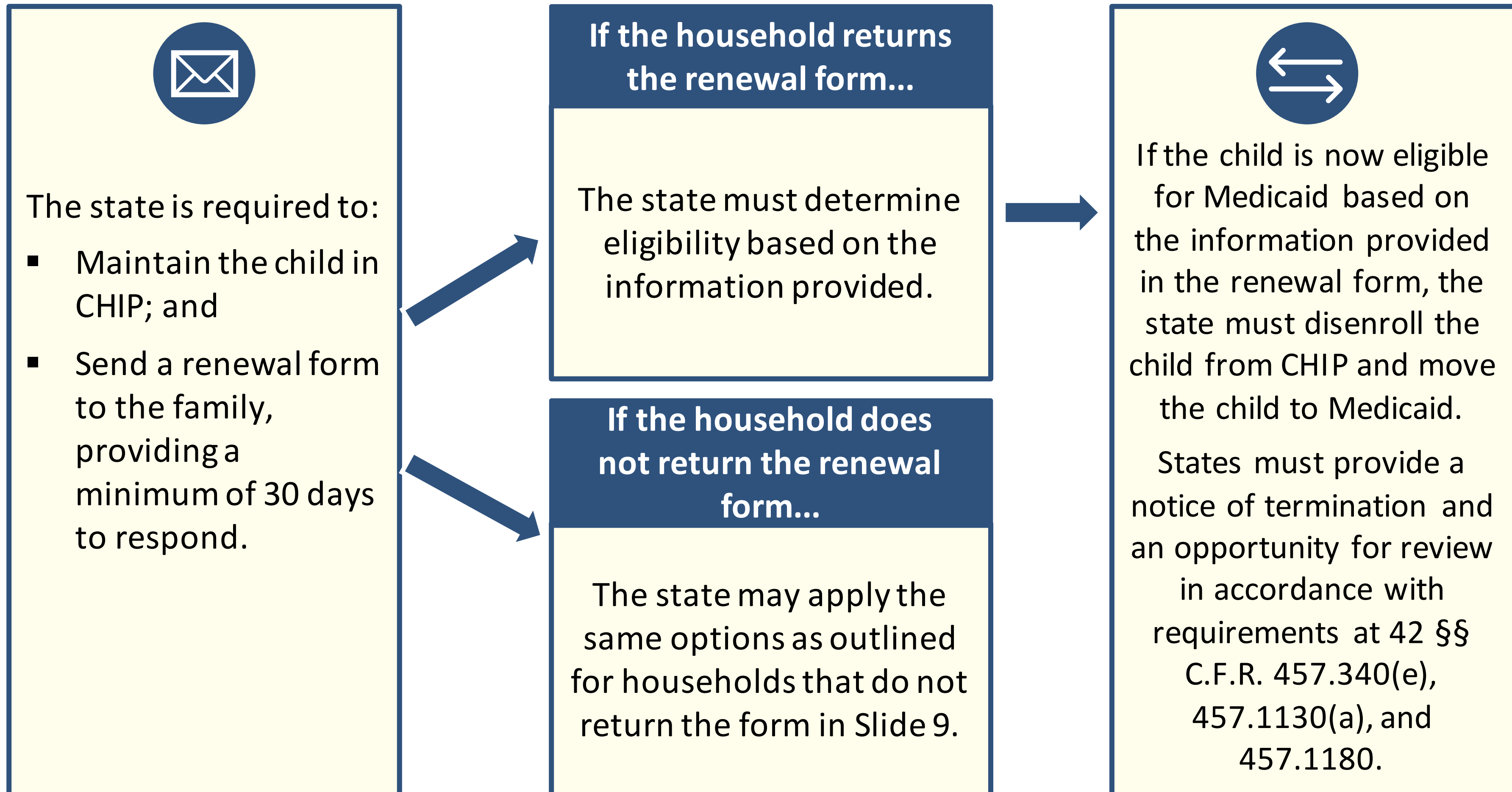
- When sending the Medicaid disenrollment notice for the child from Medicaid for procedural reasons send a **second request for additional information to collect the information needed to determine eligibility for CHIP**.
- If the requested information is not provided, the child is not enrolled in CHIP.

Option 3: Terminate Coverage

- The state is encouraged to include a notice with the renewal form clearly stating that a response is required to determine eligibility for CHIP.
- Disenroll the child from Medicaid, based on the non-response to the renewal form. The state must send an advance notice of termination with fair hearing rights prior to the eligibility change.
- The child is not enrolled in CHIP, regardless of the data obtained during the *ex parte* process.

CHIP Enrolled Children Who Appear Medicaid Eligible Via *Ex Parte* Review

Question: If a state conducts an *ex parte* review at renewal and a CHIP-enrolled child appears eligible for Medicaid based on available data, what are the required state actions?



Transitions Within Medicaid Eligibility Groups

Transitioning Medicaid Beneficiaries Who Are Eligible for Another Medicaid Eligibility Group with a Reduced Benefit Package or Increased Cost Sharing

Question: If a state conducts an *ex parte* review at renewal and a Medicaid beneficiary appears to be eligible for another Medicaid eligibility group with a reduced benefit package or increased cost sharing, what are the required state actions?

- States may not solely rely on data sources to move individuals to a group with a reduced Medicaid benefit package or increased cost sharing.
- States are required to:
  - Maintain the individual in their existing Medicaid eligibility group; and
  - Send a renewal form to the household.

If the household returns the renewal form…

The state should determine eligibility based on the information returned in the renewal form.

If the the information provided shows the individual remains eligible in their current Medicaid eligibility group, coverage should be renewed in that group.

- If the information provided shows that the individual is now eligible for a new eligibility group with a reduced benefit package, the state **moves the individual to the new eligibility group and coverage is renewed**.
- The state must send an advance notice informing the beneficiary of the change in eligibility including the covered benefits and/or cost-sharing, the reasons for the change and the opportunity to request a fair hearing to appeal the change in eligibility status or level of benefits or cost-sharing.

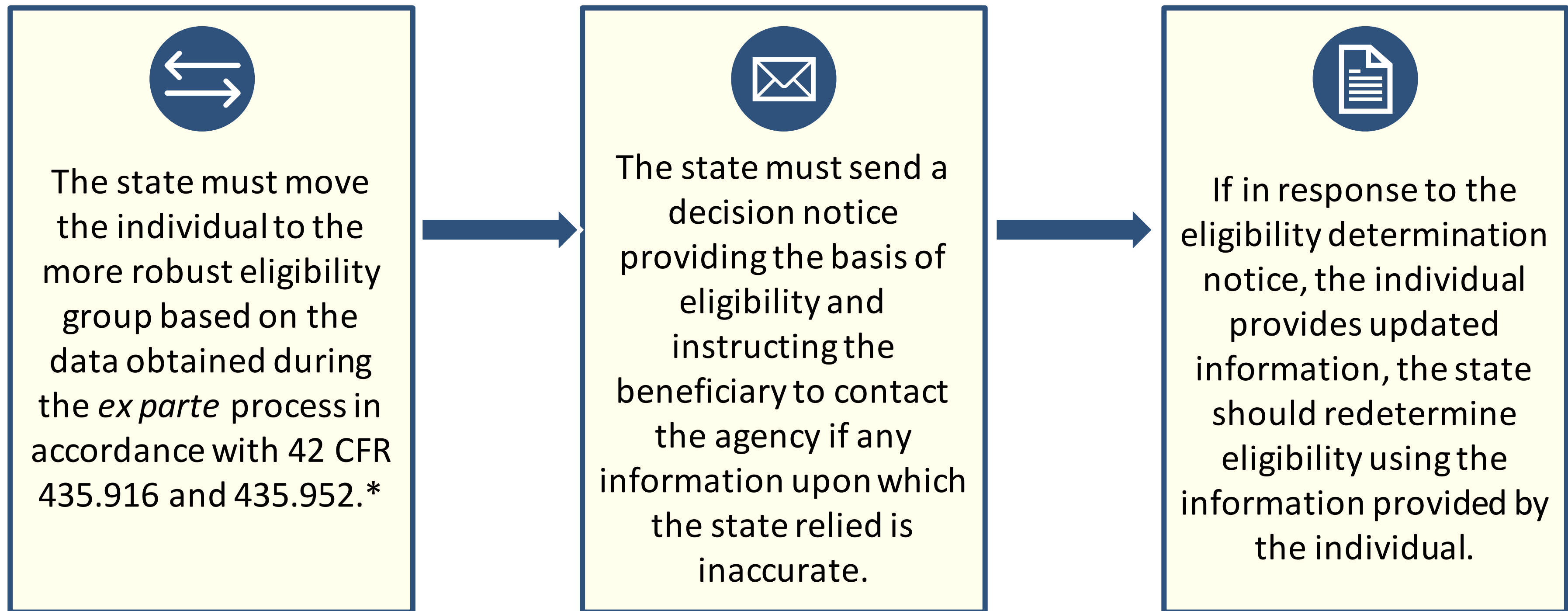
If the household does not return the renewal form…

- The state **moves the individual to the new Medicaid eligibility** group based on the data review.
- The state must send an advance notice informing the beneficiary of the change in eligibility including the covered benefits and/or cost-sharing, the reasons for the change and the opportunity to request a fair hearing to appeal the change in eligibility status or level of benefits or cost-sharing.

42 C.F.R Part 431 Subpart E.

Transitioning Medicaid-Enrolled Individuals Who Are Eligible for a Medicaid Eligibility Group with a More Robust Benefit Package

Question: If the state conducts an *ex parte* review and the Medicaid-enrolled individual appears to be eligible based on the available data for a Medicaid eligibility group with a more robust benefit package (e.g., an individual is enrolled in the Medicaid family planning group but appears eligible for full scope MAGI Medicaid) what are the required state actions?



**Reminder that states may not transition individuals to the Marketplace based on data obtained during the ex parte process. States must first send a renewal form requesting additional information to conduct an eligibility determination.*

Medicaid Enrolled Individual Who Appears Eligible for a Medicare Savings Program Group or Transitional Medicaid Assistance (TMA)

Question: If an individual enrolled in a full-benefit eligibility group appears to be ineligible for a full benefit eligibility group and eligible for a Medicare Savings Program group or TMA based on an *ex parte* data review but does not return the renewal form, what are the required state actions?

The state must not move a Medicaid enrolled individual in full Medicaid coverage who appears to be ineligible for full benefit eligibility group to a Medicare Savings Program group or TMA based only on data sources without first sending the individual a renewal form and requesting information necessary to confirm eligibility for full Medicaid.

If the individual does not return the renewal form, the state **must enroll the individual into a Medicare Savings Program group or TMA** based on the information provided from the data review.

The state must provide the individual notice of enrollment in a Medicare Savings Program group or TMA, with a minimum of 10 days advance notice and fair hearing rights before full Medicaid coverage is terminated.

For additional information on transitions to the Transitional Medical Assistance Program (TMA), see https://www.medicaid.gov/media/166466.